Orthodontic Referral

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Clarence Street DENTAL Group

Please email the ***completed*** referral form to info@clarencestreetdental.com or fax it to 519-756-0745.

Patient's Name: _____

Parents' Names: _____

Date of Birth: _____

Phone: _____

Email: _____

Referring Clinician: _____

Clinic Phone: _____

Clinic Email: _____

Type of Treatment: ❑ Braces ❑ Clear Braces ❑ Invisalign ❑ Retainer

Has the patient previously had orthodontic treatment? ❑ Yes ❑ No

Details of previous treatment: _____

_____

_____

X-rays being sent with referral: _____

Payment is due at the time of service via debit, cash, Visa, or MasterCard. We submit insurance claims on our patients' behalf and the insurance company will reimburse them directly. We regret to inform that we do not accept ODSP or HSO as a form of payment with our specialists.